APPLICATION FOR CERTIFICATION AS A PHARMACY TECHNICIAN (CPT)

State Form 51635 (2-04)
Approved by State Board of Accounts, 2004

INDIANA BOARD OF PHARMACY

FOR OFFICE USE ONLY	
APPLICATION/PERMIT FEE	
DATE FEE PAID	
RECEIPT NUMBER	
LICENSE NUMBER ISSUED	
PERMIT NUMBER ISSUED	
DATE LICENSE ISSUED	

PLEASE CHECK ALL THAT APPLY:

☐ I have completed a program of education and training approved by the Board. (*Please include verification completion of the program and / or training.*)

☐ I have passed a certification examination offered by a nationally recognized certification body, approved by the Board. (*Please include a copy of your certificate.*)

☐ I have worked as a Pharmacy Technician for at least 2 years, prior to July 1, 2003.

If you did not check at least one of the above, you must apply for a Pharmacy Technician-in-Training Permit.

I am applying for a Pharmacy Technician-in-Training Permit: ☐ Yes ☐ No

Name of applicant (*last, first, middle, maiden or previous*)	
Current address (*number and street or Rural Route*)	
City, state, ZIP code	
Permanent address (*if different from address above*)	
City, state, ZIP code	
Work telephone number (*include area code*)	Home telephone number (*include area code*)
Email	
Date of birth (*month, day, year*)	Place of birth (*city and state*)
Social Security number (*required*) *	

MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBER

* Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that disclosure of your U.S. Social Security number on your application is mandatory for the purpose of complying with IC 25-1-5-8 and IC 4-1-8-1 which provide that the Indiana Department of Revenue may obtain Social Security number from the Health Professions Bureau for tax enforcement purposes. In addition, disclosing such number is mandatory in order for the licensing board or committee to comply with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank 42 U.S.C. § 1320(a)-7e(b), 5 USC §552a, 45 CFR Part 60.1, and 45 CFR Part 61.

Failure to disclose your U.S. Social Security number will result in the denial of your application. Application fees are not refundable.

(*Continued on the reverse side*)

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No

3. Are you now being, or have you ever been treated for a drug abuse or alcohol problem? ☐ Yes ☐ No

4. Have you ever been convicted of, pled guilty or *nolo contendre* to, or are formal charges pending for:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances? ☐ Yes ☐ No
   B. Any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines.)* ☐ Yes ☐ No

5. Have you ever been denied employment in a pharmacy, or had such employment revoked, suspended or subjected to any restriction, probation or other type of discipline of limitations? ☐ Yes ☐ No

6. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request, and direct any person, firm, officer, corporation, association, organization, or institution to release to the Health Professions Bureau of Indiana, or the Indiana Board of Pharmacy, any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or the Board, or any of their authorized representatives, in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations, and institutions from any liability with regard to such inspection to furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana, or the Indiana Board of Pharmacy, to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Bureau, and the Board from any and all liability in connections with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.